MELBOURNE EAR SPECIALISTS

NEW PATIENT REGISTRATION FORM

Please complete this form and return it to the office before your appointment. Alternatively, you can complete our online form at melbourne-ear.com.

SURNAME: .....Prof / Dr / Mr / Mrs / Ms / Miss / Mstr

GIVEN NAMES: .....

ADDRESS: .....

SUBURB: .....POSTCODE: .....

DATE OF BIRTH: ..... AGE: .....

EMAIL ADDRESS: .....

HOME PHONE NUMBER: ..... MOBILE NUMBER: .....

NEXT OF KIN: .....

RELATIONSHIP: ..... PHONE NUMBER: .....

REFERRING DOCTOR: .....

ADDRESS: .....

SUBURB: .....POSTCODE: .....

TELEPHONE: .....FAX: .....

MEDICARE NUMBER: .....

REFERENCE NUMBER: .....EXPIRY: .....

PRIVATE HEALTH INSURANCE FUND: .....

MEMBER NUMBER: ..... LEVEL OF COVER:.....

VETERAN AFFAIRS (GOLD CARD ONLY) VX NUMBER: .....

AGED PENSION NUMBER: .....

DATE OF COVID VACCINATION (1ST DOSE): ..... COVID VACCINATION (2ND DOSE): .....
Please provide a copy of your certificate if available or show staff at time of appointment.

PLEASE LIST ANY OTHER DOCTORS YOU ARE SEEING:

NAME: ..... LOCATION: ..... PHONE NUMBER: ..... SPECIALITY: .....

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www.melbourne-ear.com
admin@melbourne-ear.com

Suite 222, 100 Victoria Parade,
East Melbourne, VIC 3002

p. +613 9650 0522
f. +613 9650 2522

IS THIS WORK COVER/TAC CLAIM? YES/NO

IF YES:

EMPLOYER: .....

ADDRESS: .....

SUBURB: ..... POSTCODE: .....

WORKCOVER INSURER: .....

ADDRESS: .....

SUBURB: ..... POSTCODE: .....

DATE OF ACCIDENT: ..... CLAIM NUMBER: .....

HAS THIS CLAIM BEEN APPROVED: YES/NO

CONSENT FORM

We require your consent to collect personal information about you. Please read this information carefully and sign where indicated below.

This medical practice collects information from you for the primary purpose of providing quality health care. We require you to provide us with your personal details and a full medical history so that we may properly assess, diagnose, treat and be proactive in your health care needs. This means we will use the information you provide in the following ways:

- Administrative purposes in running our medical practice.
- Billing purposes, including compliance with Medicare and Health Insurance Commission requirements.
- Disclosure to other doctors in the practice, locums and Registrars attached to the practice for the purpose of patient care and teaching.
- Please discuss with Prof Briggs if you do not want your records accessed for these purposes.
- Disclosure for research and quality assurance activities to improve individual and community health care and practice management.

I have read the information above and understand the reasons why my information must be collected. I am also aware that this practice has a privacy policy on handling patient information.

I understand that I am not obliged to provide information requested of me, but my failure to do so might compromise the quality of the health care and treatment given to me.

I am aware of my right to access the information collected about me, except in some circumstances where access might legitimately be withheld. I understand I will be given an explanation in these circumstances.

I understand that if my information is to be used for any other purpose other than set out above, my further consent will be obtained.

I consent to the handling of my information by this practice for the purposes set out above, subject to any limitations on access or disclosure that I notify this practice of.

Signed: ..... DATE: .....

PATIENT

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